Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4564AGC	A. BUILDING _____ B. WING _____	03/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JTM GROUP CARE	1435 AKARD DRIVE RENO, NV 89503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 3/16/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was seven. Seven resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000	4-4-11 approved POC cg	
Y 103 SS=C	449.200(1)(d) Personnel File - NAC 441A / Tuberculosis NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.	Y 103	dw cg EMPLOYEE #3 TOOK TB TEST ON MARCH 25, 2011 AND THE RESULT IS POSITIVE. EMPLOYEE WILL GO BACK TO THE CLINIC FOR CHEST X-RAY ON APRIL 1, 2011	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: OWNER — (X6) DATE: 3/30/11

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Y 103	Continued From page 1 This Regulation is not met as evidenced by: Based on record review on 3/16/11, the facility failed to ensure 1 of 4 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing for the protection of all residents (Employee #3 - missing documentation of positive PPD skin test). Severity: 1 Scope: 3	Y 103		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review and interview on 3/16/11, the facility failed to ensure that 1 of 7 residents received medications as prescribed (Resident #3 - missing CoEnzyme Q10 - a dietary supplement). Severity: 2 Scope: 1	Y 878 gk cg	ALL EMPLOYEES WILL BE RESPONSIBLE TO CHECK PHYSICIAN'S ORDER AND MAR TO MAKE SURE BOTH ARE IN ORDER, AND TO COMMUNICATE WITH FAMILY TO HAVE THE MEDICATION IN THE GROUP HOME.	